COUNTERSTATEMENT

1. The Medicare Reopening Regulation. In addition to the vertical appeal process established under 42 U.S.C. § 1395oo (Pet. 2-3) for review of Medicare payment determinations, the Secretary's regulations provide for horizontal review of payment determinations through reopening. *See* 42 C.F.R. § 405.1885. The reopening regulations provide for both discretionary and mandatory reopening. Section 405.1885(a), the subsection governing discretionary reopening, provides that a payment determination "may" be reopened within a three-year window upon request of a provider or upon the motion of the Secretary's contractor, the fiscal intermediary. *See* Pet. 2-3. A decision denying a request for discretionary reopening under subsection (a) is not subject to review. *Your Home Visiting Nurse Servs., Inc.* v. *Shalala*, 525 U.S. 449, 452-57 (1999).

This case is about mandatory reopening under 42 C.F.R. § 405.1885(b). As it existed at the relevant time—in 1997—subsection (b) directed that a payment determination "*shall* be reopened and revised * * * within the aforementioned 3-year period," if "HCFA [now the Centers for Medicare and Medicaid Services ("CMS")] notifies the intermediary that such determination is inconsistent with applicable law, regulations, or general instructions issued by [CMS] in accordance with the Secretary's agreement with the intermediary." 42 C.F.R. § 405.1885(b). A notice of inconsistency with law triggers a mandatory, automatic duty to reopen. *Monmouth*, App. 45a. *See also Bartlett Mem. Med. Ctr.* v. *Thompson*, 347 F.3d 828, 837-38 (10th Cir. 2003). Whenever a Medicare payment determination is reopened, and regardless of whether reopening was effected under subsection (a) or (b), the determination is not "final and binding" as to the matters at issue in the reopening. *See* 42 C.F.R. §§ 405.1807, 405.1885, 405.1889.

In 2002, the Secretary amended subsection (b) in response to the D.C. Circuit's decision construing that regulation in *Monmouth* (discussed below), and the decision of a district court that had followed *Monmouth*. 67 Fed. Reg. 49,982 (Aug. 1, 2002). As amended, the regulation now requires, in addition to the notice of inconsistency, an explicit direction by the agency "to reopen and revise the intermediary determination." *Id.* at 50,110.

2. The Medicare Payment Adjustment For A Disproportionate Share Hospital. For most hospitals, the Medicare payment for the operating costs of inpatient hospital services is based on preset, standardized rates per discharge, subject to certain adjustments. *See* 42 U.S.C. § 1395ww(d); *Baystate*, App. 3a. One of the payment adjustments is the "disproportionate share hospital" (or "DSH") adjustment, which is a percentage add-on to the standardized rates paid to hospitals that serve a disproportionate share of low-income patients. 42 U.S.C. § 1395ww(d)(5)(F); 42 C.F.R. § 412.106; *Baystate*, App. 3a.[2]

---

[2] During the years following congressional authorization of the DSH payment in 1983, Congress repeatedly expressed concerns about the Secretary's lack of effort to define a DSH and the agency's failure to implement the DSH adjustment "in any meaningful way." *See* H.R. Rep. No. 99-241, at 16 (1986), *reprinted in* 1986 U.S.C.C.A.N. 579, 594; *see also* H.R. Conf. Rep. No. 98-861, at 1356 (1984), *reprinted in* 1984 U.S.C.C.A.N. 1445, 2044. Since then, several courts likewise have commented on the agency's apparent hostility toward the DSH adjustment. *See Portland Adventist Med. Ctr.* v. *Thompson*, 399 F.3d 1091, 1099 (9th Cir. 2005) ("This appears to be the latest in a series of cases in which the Secretary has refused to implement the DSH provision in conformity with the intent behind the statute."); *Clark Reg'l Med. Ctr.* v. *United States Dep't of Health & Human Servs.*, 314 F.3d 241, 249 (6th Cir. 2002) ("[T]he Department cannot simply interpret the [DSH] regulation so as to always disadvantage the subject hospital."); *Jewish Hosp., Inc.* v. *Sec'y of Health & Human Servs.*, 19 F.3d 270, 276 (6th Cir. 1994) (noting "credible

Under the statutory criteria in effect during the periods at issue here, a hospital's qualification for a DSH adjustment and the amount of that adjustment generally are based on the hospital's "disproportionate patient percentage." That percentage is defined as the sum of two fractions that function as proxies for inpatient hospital utilization by low-income individuals. 42 U.S.C. §§ 1395ww(d)(5)(F)(v), (vi).

This case concerns the composition of the numerator of one of those fractions, the so-called "Medicaid fraction." As defined in the Medicare Act, the numerator of a hospital's Medicaid fraction for a fiscal year consists of:

> [T]he number of the hospital's patient days for such period which consists of patients who (for such days) were ***eligible*** for medical assistance under a State plan approved under [the Medicaid statute], but who were not ***entitled*** to benefits under part A of [the Medicare statute].

42 U.S.C. § 1395ww(d)(5)(F)(vi)(II) (emphasis added).

3. The Secretary's Invalid DSH Rule. From the start, the Secretary's regulations were at odds with the statutory definition of the Medicaid fraction. While the statute counts all days attributable to patients who were "eligible" for Medicaid but not "entitled" to Medicare benefits, from 1986 through 1997, the Secretary's DSH regulation literally substituted "entitled" for "eligible." *See* 42 C.F.R. § 412.106(b)(4) (1997) (defining the numerator of the Medicaid fraction to consist of days attributable to patients who were "entitled to Medicaid but not to Medicare part A"). Under this regulation, the Secretary allowed hospitals to count only those days for which a Medicaid-eligible patient was entitled to have Medicaid payment made on his or her behalf. *See* 51 Fed. Reg. 16,772, 16,788 (May 6, 1986); 51 Fed. Reg. 31,454, 31,460 (Sept. 3, 1986). The effect of the

---

and compelling" evidence of the agency's "hostil[ity] to the concept of the disproportionate share adjustment").

Secretary's restrictive interpretation of the DSH statute was to reduce DSH payments to hospitals, in that a hospital might not be paid by Medicaid for some portion of a Medicaid-eligible patient's stay for any number of reasons having nothing to do with the patient's low-income status or eligibility for Medicaid.[3]

Between 1994 and 1996, all four of the federal circuit courts that considered the Secretary's DSH rule invalidated it, holding that the regulation was inconsistent with the plain meaning of the DSH statute because it conflated eligibility and entitlement.[4] *See Cabell Huntington Hosp.* v. *Shalala*, 101 F.3d 984, 990 (4th Cir. 1996) (characterizing the Secretary's regulation as an attempt to "rewrite the will of Congress" by an agency that has been "hostile from the start to the very idea of making the payments at issue"). The Secretary did not seek Supreme Court review of any of the adverse circuit court decisions; nor did his interpretation prevail in any other case.

4. Ruling 97-2. On February 27, 1997, the Secretary issued Ruling 97-2. App. 49a.[5] In that Ruling, issued

---

[3] For example, because Medicaid is the "payer of last resort," *New York State Dep't of Social Servs.* v. *Bowen*, 846 F.2d 129, 133 (2d Cir. 1988), a Medicaid-eligible patient is not entitled to have Medicaid payment made if some other person is liable for medical expenses.

[4] *See Cabell Huntington Hosp.* v. *Shalala*, 101 F.3d 984 (4th Cir. 1996); *Legacy Emanuel Hosp. & Health Ctr.* v. *Shalala*, 97 F.3d 1261 (9th Cir. 1996); *Deaconness Health Servs. Corp.* v. *Shalala*, 83 F.3d 1041 (8th Cir. 1996) (per curiam); *Jewish Hosp., Inc.* v. *Sec'y of Health & Human Servs.*, 19 F.3d 270 (6th Cir. 1994).

[5] The version of Ruling 97-2 appended to the petition, App. 49a, is incorrect. It omits language in the official version regarding the binding nature of CMS rulings on all components of the agency. A complete version of Rul-

without notice and comment, the agency changed its DSH rule. While insisting that the agency believed that its prior DSH rule was "permissible," the agency conceded that it "is contrary to the applicable law in four judicial circuits." *Id.* at 51a. The Ruling announced the agency's determination "to follow the holdings" of the circuit courts and to count all Medicaid-eligible days in the Medicaid fraction, regardless of whether the patient was actually entitled to have Medicaid payment made for those days. *Id.* at 50a-52a.[6]

5. The Retroactive Effect of the Ruling. In Ruling 97-2, the Secretary stated that the agency would count all Medicaid-eligible days "on a prospective basis." *Id.* at 51a. That characterization is not entirely accurate. The Ruling was effective for "hospital cost reports that are settled by fiscal intermediaries on or after the effective date of this ruling"—which necessarily included cost reports for prior years. For example, Ruling 97-2 applied by its terms to a determination issued after February 1997 with respect to a hospital cost report filed in 1996 for a fiscal period ending in 1995.

Ruling 97-2 therefore established a new substantive rule for determining payments made for *prior* fiscal periods—the hallmark of a retroactive rule. *See Bowen* v. *Georgetown*

---

ing 97-2 is published on the agency's website at http://www.cms.hhs.gov/Rulings/downloads/hcfar972.pdf.

[6] In 1998, the Secretary amended the DSH regulation to conform it to Ruling 97-2. In the accompanying preamble, the Secretary confirmed that the Ruling had been issued to "acquiesce[] in the four adverse appellate court decisions," 63 Fed. Reg. 25,576, 25,594 (May 8, 1998), and to "change[] the agency's statutory construction to comport with those decisions," *see id.* and 63 Fed. Reg. 40,954, 40,985 (July 31, 1998). The new regulations, in turn, were "intended simply to conform the regulations to HCFA Ruling 97-2 (and hence to the four adverse court decisions)." 63 Fed. Reg. at 40,985.

Univ. Hosp., 488 U.S. 204 (1988) (Secretary lacks authority to promulgate a new rule for determining payments to hospitals for prior years). The Ruling expressly forbade reopening of prior DSH payment determinations, however, App. 52a, regardless of whether such determinations were within the three-year reopening window when the Ruling issued.

6. ***Monmouth.*** In *Monmouth*, App. 31a, the D.C. Circuit unanimously ruled that mandamus should issue to compel the Secretary to reopen DSH determinations rendered within the three-year reopening period that preceded Ruling 97-2. The court of appeals explained that, by issuing the Ruling without invoking notice and comment rulemaking procedures, the Secretary had given notice that prior DSH determinations rendered under the agency's original interpretation of the statute were "inconsistent with law," as determined by all four circuits that had considered the matter. The Secretary's notice of inconsistency with law triggered a mandatory and "automatic" duty to reopen the prior DSH determinations under subsection (b) of the Secretary's reopening regulations. App. 41a, 45a. The Secretary's directive in Ruling 97-2 that no reopenings occur therefore was a "nullity" in light of the clear legal duty that arose under his own reopening regulations. *Id.* at 43a-45a (citing, *inter alia*, *Dixon* v. *United States*, 381 U.S. 68, 74 (1965)).

The Secretary petitioned the court of appeals to rehear the case en banc. That petition was denied with no votes in favor of it, and the Secretary did not seek certiorari.

7. ***Baystate.*** Respondents are 26 public and private nonprofit hospitals that sued the Secretary in March 2002, approximately eight months after the D.C. Circuit decided *Monmouth*. They sought relief in the nature of mandamus compelling the Secretary to reopen DSH payment determinations that were issued within the three-year reopening window preceding Ruling 97-2, on grounds that, under *Mon-*

mouth, the Ruling triggered mandatory and automatic reopening under subsection (b).[7]

The district court granted the hospitals' motion for summary judgment. App. 12a. A unanimous panel of the D.C. Circuit affirmed, App. 1a, concluding that the hospitals were not required to request discretionary reopening under Section 405.1885(a) in order to qualify for mandatory reopening under Section 405.1885(b), and that the district court acted within its discretion in balancing the equities on mandamus in favor of the hospitals. App. 7a-11a. The Secretary petitioned for rehearing en banc. That petition garnered no votes and was denied. The court of appeals later denied the Secretary's motion to stay the mandate.

REASONS FOR DENYING THE WRIT

The Secretary's petition belies his assertion that this case presents an important federal question warranting this Court's attention. *Baystate* itself poses no such question, as is evident both from the Secretary's Question Presented (which identifies no issues of any broad significance) and from the text of the petition itself, the bulk of which consists of a diffuse complaint about no fewer than three unanimous decisions of the D.C. Circuit. Indeed, the Secretary's petition amounts to a generic appeal from the adverse decisions below. But this Court sits to settle important questions of federal law, not as an additional appellate option for disappointed litigants.

The writ should be denied for the following reasons:

1. The petition does not urge that the court of appeals' decision on the narrow question presented in this case—whether the mandatory duty to reopen under subsection

---

[7] By agreement of the parties and the district court, *Baystate* is the lead case among approximately 250 similar cases, consolidated and presently stayed below.

(b) should be enforced in the absence of a request for discretionary reopening under subsection (a)—is sufficiently important to warrant further review. Indeed, that aspect of the decision is not in conflict with the decision of any court.

2. The prior D.C. Circuit decisions the petition challenges similarly do not warrant review. The asserted "circuit split" between *Monmouth* and *Bartlett* is shallow and stale. It is shallow because the split is alleged on a narrow issue in which just two circuits—one of them by a 2-1 vote—have disagreed. And it is stale because the issue in both cases turned on the particular reopening regulation in effect when the Ruling issued in 1997. That regulation was unique in the entire Code of Federal Regulations, and the Secretary has since amended it to resolve the split he complains about here.

3. The petition also alleges a "conflict" between the D.C. Circuit's decision nine years ago in *Paralyzed Veterans* and two decisions of the First and Ninth Circuits (Pet. 25). That "conflict" is not presented in *Baystate*; certiorari should not be granted to address an issue not presented in this case. Nor, for that matter, is the asserted conflict a genuine one. *Paralyzed Veterans* and the decisions the Secretary contends are in tension with it all are consistent with this Court's precedent. *See Shalala* v. *Guernsey Mem. Hosp.*, 514 U.S. 87, 100 (1995).

4. The Secretary does not directly challenge the D.C. Circuit's holding that the district court acted within its discretion in finding that the equities in this case weigh in favor of the hospitals. App. 9a-11a. He does offer self-serving allegations about the administrative and financial impact of this case on his agency, Pet. 27-30, but those allegations do not support granting certiorari. The petition's representations about the potential impact of the decision are both newly revised from representations previously made and do not square with statements made since: In his most recent filing with the district court, the Secretary refused to engage

in what he characterized as "rank speculation" about the impact of the court of appeals' decision in *Baystate*.[8]

5. The D.C. Circuit's decisions in *Monmouth* and *Baystate* are correct. Crediting the Secretary's actions over the self-serving statements in Ruling 97-2, the court of appeals in *Monmouth* properly compelled the agency, consistent with this Court's decisions in *Morton* v. *Ruiz*, 415 U.S. 199 (1974), and *United States ex rel. Accardi* v. *Shaughnessy*, 347 U.S. 260 (1954), to perform the mandatory reopening duty that arose under the Secretary's own rules. In addition, consistent with this Court's decisions in *Bethesda Hospital Association* v. *Bowen*, 485 U.S. 399 (1988), and *Shalala* v. *Illinois Council on Long Term Care, Inc.*, 529 U.S. 1 (2000), the court of appeals in *Baystate* did not require the hospitals to pursue unavailable, futile, and unnecessary administrative remedies before suing to vindicate their right to mandatory reopening.

I. THE PETITION IDENTIFIES NO SIGNIFICANT CONFLICT WITH THE DECISIONS OF OTHER CIRCUITS.

1. *Baystate* presents no circuit conflict. Having ruled in *Monmouth* that Ruling 97-2 gave notice of inconsistency with law, triggering the mandatory reopening duty under subsection (b), the court of appeals held in *Baystate* that the obligation to reopen may be enforced against the Secretary even if the hospitals did not timely request discretionary reopening under subsection (a).[9] The court's decision on this

---

[8] Defendant's Reply in Further Support of Motion to Stay Proceedings, at 9, Misc. No. 03-0090 (D.D.C. Feb. 16, 2006).

[9] This holding is not a "dramatic extension" of *Monmouth*. *See* Pet. 9. *Monmouth* had already held that the reopening guaranteed by subsection (b) was mandatory and "automatic" upon issuance of a notice of inconsistency with law. App. 41a, 45a. In light of that, the holding in *Baystate* that there was nothing the hospitals had to do to perfect their reopening right is hardly surprising. *See*

narrow question does not conflict with any decision of any other court, including the Tenth Circuit. While the Secretary generally complains that *Baystate* was wrong, he quite properly does not assert that this aspect of the decision—the only new issue presented in *Baystate*—warrants this Court's attention. *See* Pet. 22-30.

2. The conflict about which the Secretary complains is instead between the portion of *Baystate* that relies on the prior unanimous decision in *Monmouth*, and the Tenth Circuit's split panel decision in *Bartlett*. That shallow split does not raise any important question of federal law.

To begin with, the underlying conflict between *Monmouth* and *Bartlett*, such as it is, does not relate to whether mandamus jurisdiction is available or to the requirements for mandamus relief. Nor is there any conflict between *Monmouth* and the *Bartlett* majority over whether subsection (b) requires reopening upon issuance of the requisite notice of inconsistency with law. Both courts agree that it does. *Monmouth* and *Bartlett* part ways only on the narrow question whether Ruling 97-2 in fact gave notice of inconsistency with law and whether subsection (b) required specific intent on the Secretary's part to compel reopening when the notice was issued. *See Bartlett*, 347 F.3d at 839 (rejecting *Mon-*

Baystate, App. 8a. After the panel decision in *Monmouth*, moreover, the Secretary plainly was not operating on the assumption that it would take a "dramatic extension" of that decision to visit substantial liability on the agency. In fact, the Secretary's unsuccessful petition for rehearing en banc in *Monmouth* included the assertion that the impact of that decision "could total as much as $3.25 billion." Petition for Rehearing and Suggestion for Rehearing En Banc, at 3, Nos. 00-5109 & 00-5110 (D.C. Cir. Sept. 10, 2001). The Secretary's failure to seek certiorari then, when the agency was estimating an even greater impact than what it forecasts now (*see* Part III, *infra*), belies the Secretary's assertion that the *Monmouth* decision is sufficiently important to warrant review on certiorari now.

mouth "because it makes assumptions about the premises and intended effect of Ruling 97-2 that *do not comport with fact or with the clear intention of the Secretary*") (emphasis added). That narrow disagreement does not warrant review by this Court. S. Ct. Rule 10; *cf. United States* v. *Johnston*, 268 U.S. 220, 227 (1925) (this Court "do[es] not grant a certiorari to review evidence and discuss specific facts").

Whatever difference there is between the Tenth and D.C. Circuit panels over the 1997 version of subsection (b) also has little, if any, continuing significance. The Secretary amended his reopening regulation in 2002; since then, a notice of inconsistency with law will only trigger reopening in the Medicare context if it is accompanied by an express direction to reopen from the Secretary. *Compare* 42 C.F.R. § 405.1885(b) (1997) *with* 42 C.F.R. § 405.1885(b) (2002). The Secretary thus has resolved the *Monmouth/Bartlett* split himself, ensuring that *Monmouth* and *Baystate* will not require reopening with respect to Medicare notices issued after 2002. [10] Nor is the issue likely to recur in other contexts; the Secretary cites no other regulation anywhere in the Code of Federal Regulations (and respondents are unaware of any) that operates as subsection (b) once did—to compel reopening solely upon the issuance of a notice of inconsistency with law.

3. The next "conflict" the Secretary alleges is between a statement in the D.C. Circuit's 1997 decision in *Paralyzed Veterans* and two later decisions of the First and Ninth Circuits (in 1998 and 2004, respectively). There is no genuine conflict here, either. First of all, the statement with

---

[10] The "additional mandamus litigation" that the Secretary identifies (Pet. 29-30) relates to other agency actions preceding his 2002 amendments to the reopening rules. "[T]he Secretary believes that the 2002 amendments to the reopening rule should prevent future mandamus actions to force reopening in cases governed by the amended rule." Pet. 27.

which the Secretary takes issue was, the Secretary concedes, "dictum" in *Paralyzed Veterans*, only "later elevated * * * to a holding" in *Alaska Professional Hunters* v. *FAA*, 177 F.3d 1030 (D.C. Cir. 1999). *See* Pet. 24 n.5. Second, certiorari was sought in *Paralyzed Veterans* and was denied. 523 U.S. 1003 (1998). And third, the later First and Ninth Circuit decisions allegedly in "conflict" with *Paralyzed Veterans* both endorse the proposition, stated in that case and in the earlier case of *American Mining Congress* v. *Mine Safety and Health Administration*, 995 F.2d 1106, 1112 (D.C. Cir. 1993), that interpretive rules that effectively change agency regulations require notice and comment rulemaking. *See Erringer* v. *Thompson*, 371 F.3d 625, 632 (9th Cir. 2004) (applying the principle that a rule is legislative and therefore requires notice and comment rulemaking if it is inconsistent with another rule having the force of law); *Warder* v. *Shalala*, 149 F.3d 73, 80-81 (1st Cir. 1998) (same).[11] That proposition is entirely consistent with this Court's opinion in *Guernsey Memorial Hospital*, 514 U.S. at 100. And it is that settled principle that applies here—effective amendment of a substantive rule by an interpretive rule—not just amendment of one interpretive rule by another, which is the narrow application of *Paralyzed Veterans* that the Secretary challenges. Pet. 25. *See infra* at 25-27.

For that reason, this is not the case to address *Paralyzed Veterans*, even if there were a question worth addressing. In light of *Guernsey*, *Paralyzed Veterans* is not needed to support *Monmouth's* holding regarding the operative effect of Ruling 97-2. The D.C. and Tenth Circuits in any event did not split over *Paralyzed Veterans* in *Monmouth* and *Bartlett*. And most important, *Paralyzed Veterans* is not at all relevant to *Baystate*'s narrow holding. Any conflict between *Para-*

---

[11] The Secretary does not challenge *Monmouth's* observation (App. 44a) that the codified DSH regulation that Ruling 97-2 changed was indeed a "legislative rule."

lyzed Veterans and the decisions of other circuits is best left to be addressed in a case in which the challenged principle stated in *Paralyzed Veterans* is actually at issue. *Cf. The Monrosa* v. *Carbon Black Export, Inc.*, 359 U.S. 180 (1959) (Court was compelled to dismiss a writ of certiorari as improvidently granted when the question presented in the petition turned out not to be presented in the case).

II. THE COURT OF APPEALS' DECISIONS ARE CONSISTENT WITH THE DECISIONS OF THIS COURT.

1. The Secretary argues that *Monmouth* and *Baystate* undermine important administrative interests in finality, in conflict with decisions of this Court. Pet. 21-22 (citing *Your Home*, 525 U.S. 449, *Pittston Coal Group* v. *Sebben*, 488 U.S. 105 (1988), and *ICC* v. *Brotherhood of Locomotive Engineers*, 482 U.S. 270 (1987)). That is not correct; *Monmouth* and *Baystate* are fully consistent with this Court's decisions regarding finality.

The cases the Secretary cites are demonstrably inapposite. Respondents are not trying to secure judicial review of an agency's refusal to grant a request for discretionary reopening, as was the case in *Locomotive Engineers* and *Your Home*. Nor are the hospitals trying to pursue an unauthorized further review of a determination the agency is under no obligation to reopen again, as was the case in *Sebben*, 488 U.S. at 110, 121-22. Rather, respondents brought this action to vindicate their right to the *mandatory* reopening required by the Secretary's own regulations upon a notice of inconsistency. *Monmouth* and *Baystate* are predicated on the notice of inconsistency with law the Secretary gave when he issued Ruling 97-2 and the *sui generis* reopening regulation in effect when that notice was given.

In view of the plain meaning of subsection (b) of the Secretary's 1997 reopening regulation, the rest of what the Secretary has to say about the importance of "finality" is beside

the point. And, as there appears to be no other federal regulation that operates as subsection (b) once did, the D.C. Circuit's decisions in *Monmouth* and in this case could not possibly have any "chilling" effect on any agency's decision to acquiesce in judicial decisions in the future, as the Secretary suggests.

2. The D.C. Circuit also acted consistent with this Court's precedents when it properly compelled the Secretary to follow his own rules. The Secretary suggests that *Monmouth* and *Baystate* are "in tension" with this Court's decisions in *Your Home* and *Thomas Jefferson University* v. *Shalala*, 512 U.S. 504 (1994). According to the petition, the agency was under no obligation to issue a notice of inconsistency with law, and the court of appeals therefore should have deferred to the Secretary's statement in Ruling 97-2 that his "acquiescence" was "prospective." Pet. 13-17. But the question in *Monmouth* was not whether the Secretary was required to give notice; it was whether he did give notice and what obligations follow from that act.

The D.C. Circuit correctly determined in *Monmouth* that whatever else the Secretary may have said when he issued the 1997 Ruling, his determination to follow the holdings of the four circuit courts that ruled the prior DSH rule invalid, together with the manner in which he effected that acquiescence, in fact gave notice of inconsistency and thereby triggered a mandatory duty to reopen under Section 405.1885(b). This Court's precedents do not require or permit the lower courts to privilege an agency's contradictory and self-serving pronouncements over the clear dictates of its regulations. "[I]t is incumbent upon agencies to follow their own procedures * * * even where the internal procedures are possibly more rigorous than otherwise would be required." *Morton* v. *Ruiz*, 415 U.S. 199, 235 (1974). *See Accardi*, 347 U.S. at 267-68 (requiring agency adjudicative board to exercise its own discretion as required by regulation,

despite contrary direction by Attorney General as head of the agency).

The Secretary also expresses the view that his acquiescence in Ruling 97-2 put the agency in a worse position than it would have been in had it continued to litigate the validity of the original DSH rule after its first four appellate losses. That lament is difficult to credit, for it again amounts to nothing more than a complaint about the requirements of the Secretary's own rules. *See United States* v. *Nixon*, 418 U.S. 683, 696 (1974) (so long as a "regulation remains in force, the Executive Branch is bound by it, and indeed the United States as the sovereign composed of the three branches is bound to respect and to enforce it").[12]

3. *Monmouth* and *Baystate* are also fully consistent with this Court's decisions excusing exhaustion of unavailable or futile administrative remedies. The Secretary therefore is incorrect in contending that the decisions ran afoul of *Heckler* v. *Ringer*, 466 U.S. 602 (1984), because the hospitals had not pursued appeals prior to Ruling 97-2 and had not requested discretionary reopening under Section 405.1885(a).[13]

---

[12] The Secretary's revocation of his unlawful regulation came too late, in any event, for thousands of other prior erroneous DSH determinations that were final and beyond the three-year reach of any reopening by the time the Ruling issued.

[13] The Secretary also complains that the hospitals waited five years after Ruling 97-2 to seek relief in district court. Pet. 20. However, the hospitals sued only eight months after *Monmouth* made clear that the hospitals did indeed have a cause of action for reopening, despite the Ruling's express bar to reopening. The hospitals acted within the applicable statute of limitations, and the Secretary does not challenge the D.C. Circuit's finding that the Secretary suffered no prejudice from the hospitals' alleged "delay." *Baystate*, App. 9a

In the first place, it is irrelevant whether the hospitals in *Monmouth* and in this case took direct appeals from DSH payment determinations issued before Ruling 97-2. As in *Monmouth*, the hospitals in this case seek to compel *reopening* of their payment determinations under a separate regulatory mechanism. The question is not whether the hospitals did all they could to "vindicate their claims to payment," Pet. 13, but rather, as *Monmouth* properly framed it, "whether [the hospitals] have done all they can to vindicate their right to *reopening*." *Monmouth*, App. 45a (emphasis added) (quoted with approval in *Bartlett*, 347 F.3d at 837).

The only reopening that a hospital has any role in initiating is discretionary reopening under subsection (a), Pet. 14, and as the D.C. Circuit correctly concluded in both *Monmouth* and this case, that avenue was foreclosed before and after Ruling 97-2. App. 35a. Before the Ruling, the applicable DSH regulation prohibited intermediaries from counting Medicaid-eligible days in the DSH payment calculation unless the patient was also entitled to Medicaid payment. After that rule was revoked, the Ruling itself expressly forbade the Secretary's intermediaries from granting provider requests for reopening. Pet. 5, 9. *See* 42 C.F.R. § 401.108. As the Secretary properly conceded below, the Medicare "intermediaries were not at liberty to ignore this bar even if they believed the ruling amounted to a notice of inconsistency." *Baystate*, App. 8a. Moreover, following the Court's decision in *Your Home*, 525 U.S. 449, hospitals have no right to administrative review of an intermediary's refusal to grant a request for discretionary reopening under subsection (a).

The Secretary nevertheless argues that the *Baystate* hospitals should have sought discretionary subsection (a) reopening anyway, if for no other reason than to "at least claim an equitable toehold to invoke mandamus." Pet. 20. Whatever that means, it is not the law. Exhaustion principles do not require hospitals to make futile requests for reopening before they can bring suit to compel reopening. *See Bethesda Hosp.*

Ass'n, 485 U.S. at 404 (hospitals are not required to request that their intermediaries grant relief proscribed by the Secretary's rules).[14]

The question that matters in this case is what the Secretary's own rules required *the agency* to do in a *mandatory* subsection (b) reopening. Subsection (b) reopenings occur automatically upon the Secretary's notice of inconsistency. Under the Secretary's reopening regulations, there is nothing the provider must do to secure mandatory reopening; indeed, there is nothing the provider *can* do. The D.C. Circuit correctly concluded as much in *Baystate* when it found that the respondent hospitals did not first need to request discretionary reopening under subsection (a) before compelling mandatory reopening under subsection (b).

---

[14] The Secretary also suggests that, futile as it would have been, the hospitals nonetheless should have requested reopening in order to satisfy the "presentment" requirement of 42 U.S.C. § 405(g). Pet. 20. Presentment, however, is a prerequisite only for the statutory judicial review that follows a final determination by the Secretary on a claim for benefits, after the administrative hearing provided for under the Medicare Act. *See Ringer*, 466 U.S. at 617 ("[T]he exhaustion requirement of § 405(g) consists of a nonwaivable requirement that a 'claim for benefits shall have been presented to the Secretary'") (quoting *Mathews* v. *Eldridge*, 424 U.S. 319, 328 (1976)). This, of course, is not such a claim; this is a mandamus action to compel reopening required by the Secretary's regulations and unlawfully withheld. *Cf. Shalala* v. *Illinois Council on Long Term Care, Inc.*, 529 U.S. 1, 19 (2000) (noting an exception to the statutory preclusion of federal question jurisdiction over claims arising under the Medicare Act when there is no available administrative remedy for vindication of the right plaintiffs seek to secure).

III. THE SECRETARY'S UNSUPPORTED ALLEGATIONS CONCERNING THE FINANCIAL AND ADMINISTRATIVE IMPLICATIONS OF THIS CASE PROVIDE NO BASIS FOR CERTIORARI.

1. The lower courts rejected the Secretary's argument that the economic impact of an adverse decision in *Baystate* counseled against mandamus relief, and those discretionary rulings go unchallenged even now. *See* Pet. 29. Yet the petition asserts, *post hoc* and without citation to any evidence in the record, that the decision in this case warrants review because it might possibly result in liability of $2.8 billion and may impose administrative burdens on the agency and its fiscal intermediaries. Pet. 27. The various figures the Secretary cites for support were not presented to the district court or the court of appeals. Respondents object to each such assertion pursuant to Supreme Court Rule 15.2.

2. The Secretary's self-described "speculation" about *Baystate*'s possible financial impact also has been inconsistent, to say the least. When the Secretary petitioned for en banc review of the panel's decision in *Monmouth*, he said at the time that the impact of that decision "could total as much as $3.25 billion."[15] He later told the district court in *Baystate* that relief should not be granted because there is "no guarantee that the end result would necessarily produce *any* financial benefit to the hospital."[16] In the court of appeals, this "zero liability" estimate grew to $1 billion, App. 11a, and

---

[15] Petition for Rehearing and Suggestion for Rehearing En Banc, at 3, Nos. 00-5109 & 00-5110 (D.C. Cir. Sept. 10, 2001).

[16] Defendant's Memorandum in Support of His Motion to Dismiss, at 15-16, No. 02-00601 (D.D.C. July 30, 2002) (emphasis added).

then to "at least $1.5 billion" by the time the Secretary sought rehearing. [17]

Since last August, the Secretary has nearly doubled that estimate in service of his arguments for certiorari, offering "$2.8 billion" as the outcome of his examination of the "actual" DSH payment records of the "affected hospitals." Pet. 27 n.7.[18] And yet, on February 16, the Secretary told the district court that his agency cannot at this time identify a single case or category of claims where the hospitals in the consolidated cases would be entitled to relief under the D.C. Circuit's decision in *Baystate*:

> Until Baystate is finally resolved, there is no way of knowing what categories of claims, *if any*, might be entitled to relief in these consolidated cases, or for that matter, what issues would be raised by different categories of claims. Consequently, any attempt to come up with abstract "categories" and procedures for determining which claims fit into which categories would be a pointless exercise in rank speculation.

See Defendant's Reply in Further Support of Motion to Stay Proceedings, at 9, Misc. No. 03-0090 (D.D.C. Feb. 16, 2001) (emphasis added).

---

[17] Appellant's Petition for Rehearing En Banc, at 2, No. 04-5203 (D.C. Cir. Aug. 15, 2005).

[18] *But compare* Defendant's Reply in Further Support of Motion to Stay Proceedings, at 4, Misc. No. 03-0090 (D.D.C. Feb. 16, 2001) (stating to the district court that the estimated financial impact of the court of appeals's decision "is not based on (and defendant did not conduct) an individualized 'investigation' of the underlying factual and legal merits of all 2,300 or so fiscal period claims raised in this litigation").

3. The petition also exaggerates the purported administrative burdens associated with the decision below. To begin with, as the D.C. Circuit observed, the burden is on the hospitals to justify their entitlement to additional DSH payment, not the other way around. App. 10a. Moreover, correcting the DSH calculation is not "exceedingly complex" (Pet. 28); it involves a single change to just one variable term—the number of Medicaid-eligible days—that appears on a single line of each hospital's Medicare cost report. The agency's protest about the "audit hours" that it (or more precisely, its fiscal intermediaries) will spend in processing the required reopenings is not only unsupported by record evidence but is also overblown and misleading.[19] The same is true of the Secretary's complaint about the number of items listed on provider cost reports.[20] And, in any event, as the district court and D.C. Circuit both observed, any increased burden on the Secretary does " 'not outweigh the public's substantial interest in the Secretary's following the law.' " App. 10a.

---

[19] The Secretary has at his disposal several tools, like sampling or the use of other reasonable proxies, that can be employed to minimize the administrative burden of reopening. *See, e.g., St. Joseph's Hosp.* v. *BlueCross BlueShield Ass'n*, [2004 Transfer Binder] Medicare & Medicaid Guide (CCH) ¶ 81,265 at 203,872 (CMS Adm'r 2004) (fiscal intermediary conducted a small-sample review of patient days to determine hospital's DSH payment); *Barnes Hosp.* v. *Mutual of Omaha*, [1994 Transfer Binder] Medicare & Medicaid Guide (CCH) ¶ 42,592 at 41,421-22 (HCFA Adm'r 1994) (applying a 1964 agreement, a 1992 amendment to the agreement, and a 1990 time study as proxies for establishing the cost of teaching residents in 1984).

[20] The vast majority of entries on a cost report go to the required reporting of the costs of services furnished to Medicare beneficiaries. In almost all cases, these items no longer have any bearing on payment to the provider; nearly all institutional providers today are reimbursed by Medicare under a prospective payment system that does not vary based on cost.

4. Finally, whatever the economic or administrative impact of the decision in this case, the salient fact is that the DSH payments at stake are funds that Congress intended the Secretary to pay to the mostly non-profit and governmental hospitals that typically qualify for these DSH payments because they incur higher costs treating a large proportion of low-income and uninsured patients.

Like all of the hospitals in the case, the great majority of the hospitals involved in the consolidated cases before the district court are non-profit, governmental or religious institutions that are located in urban areas and provide care not only for low-income Medicare and Medicaid patients but also for the millions of other low-income, uninsured patients.[21] These hospitals provide a crucial safety net in our health care system, and they incur substantial financial stress in providing high-risk care to low-income patients. Indeed, just during the pendency of this litigation, at least three of the plaintiff hospitals in the consolidated cases have gone into bankruptcy.[22]

There will be no "windfall" to these hospitals as a result of the rulings below; if anything, the hospitals are still going to come up well short of being fully reimbursed for the critical services they provided long ago. Whatever the amount at stake in these cases, it represents only the additional payments that were owed but not paid to the hospitals in unlawful Medicare payment determinations issued in the three

---

[21] *See* Robin A. Cohen, PhD, Michael E. Martinez, M.P.H., Centers for Disease Control, *Health Insurance Coverage: Estimates from the National Health Interview Survey, January – March 2005*, at 1 (2005) (reporting that 41.7 million persons were uninsured in early 2005).

[22] The hospitals are Osteopathic Medical Center of Texas, St. Vincent's Catholic Medical Center of New York, and United Hospital Medical Center of New York.

years preceding Ruling 97-2. Even as to those sums that are recoverable, the hospitals will never recoup the substantial lost time value of money, as the Medicare Act does not provide for interest on the additional payments due upon reopening. And DSH payments for prior years back to 1986 that were not subject to reopening when Ruling 97-2 issued will never be recouped, despite the fact that the Secretary's old DSH rule was just as unlawful then as it is now.

When he declined to seek certiorari in *Monmouth*, the Secretary apparently understood that not even substantial estimated liability provided a sound basis to seek this Court's review of the D.C. Circuit's unanimous decision. That reasoning should prevail all the more now. As the Secretary conceded below, "Congress imposed on the Secretary a clear statutory duty to pay the hospitals these funds." *Baystate* App. 11a. And, as the court of appeals concluded: "Having to pay a sum one owes can hardly amount to an equitable reason for not requiring payment." *Id.*

IV. THE D.C. CIRCUIT CORRECTLY DECIDED *MONMOUTH* AND *BAYSTATE*.

1. The D.C. Circuit correctly decided *Monmouth*. The court properly construed and enforced the Secretary's reopening regulation in light of the notice of inconsistency that the agency gave through Ruling 97-2. Consistent with the interpretive framework articulated in *Thomas Jefferson University*, the court correctly discerned the meaning and requirements of subsection (b) from its plain text and context.

The Secretary argues that subsection (b) did not require reopening unless the Secretary specifically directed intermediaries to reopen. But the text of the regulation itself (before the 2002 amendments) did not require any such express directive, and for good reason. The Secretary maintains that he has, and has always had, the "inherent authority to direct the actions of our own agents [*i.e.*, the fiscal intermediaries]

with respect to reopening matters under § 405.1885(a)"—the discretionary reopening provision. 67 Fed. Reg. 49,982, 50,096 (Aug. 1, 2002). That being the case, subsection (b) would serve no purpose not already subsumed within subsection (a) if subsection (b) were construed to require specific intent to reopen in addition to a notice of inconsistency with law. Because the Secretary already has inherent authority to cause his intermediaries to reopen under subsection (a) when that is what he intends to do, the D.C. Circuit was correct in declining to construe subsection (b) as serving a wholly redundant role. *See Carus Chem. Co.* v. *EPA*, 395 F.3d 434, 441 (D.C. Cir. 2005).[23]

The D.C. Circuit also properly found that Ruling 97-2 gave notice of inconsistency with law as contemplated by subsection (b). That Ruling expressly announced the agency's determination to follow the uniform holdings of four circuit courts that the Secretary's prior rule was inconsistent with the plain meaning of the controlling statute. Notably, the Ruling did not and could not say that the prior DSH rule was valid; it said only that the agency "believes" that it was a "permissible reading of the statutory language." App. 51a. All four circuit courts that considered the question had held otherwise. *See Monmouth*, App. 44a ("As a general rule, it is for the courts to determine whether or not a regulation is invalid."). If the prior DSH rule really were valid, moreover,

---

[23] The Secretary cites language in the preamble to the first iteration of a prior version of his reopening regulations in 1972, to the effect that mandatory reopening occurs upon "request" of the agency. Pet. 15 (quoting 37 Fed. Reg. 10722, 10723 (May 27, 1972)). However, the preamble does not state that such reopenings could occur "only" upon request, as the Secretary erroneously states. *Id.* More importantly, the text of the actual regulation—as was always the case until the 2002 amendments—contains no mention of any "request." Rather, the regulation makes mandatory reopening dependent on notification of inconsistency. 20 C.F.R. § 405.499g (1972); 20 C.F.R. § 405.1885(b) (1974).

then the Secretary simply could not have changed the rule without advance notice and comment rulemaking, made the new rule effective immediately in all circuits, and applied it not only prospectively but also retroactively to at least some prior fiscal years. But that is exactly what the Secretary did when the agency issued Ruling 97-2.

As *Monmouth* correctly concluded, App. 42a-43a, the issuance of the Ruling without notice and comment rulemaking could only have been permissible if the Secretary's prior interpretation was in fact a nullity, and if the Ruling were understood to convey notice of that fundamental inconsistency with law. *See Dixon* v. *United States*, 381 U.S. 68, 74 (1965); *Manhattan Gen. Equip. Co.* v. *Comm'r*, 297 U.S. 129, 134-35 (1936) (an amended regulation may apply to prior transactions that occurred when a prior, invalid rule was in place because a regulation that does not "carry into effect the will of Congress" but instead "operates to create a rule out of harmony with the statute, is a mere nullity").

In so holding, the D.C. Circuit also properly applied the sound principles reflected in *Paralyzed Veterans*. *Paralyzed Veterans* and its progeny stand for the unremarkable proposition that the APA requires notice and comment when an agency revises a putatively interpretive rule to such an extent that it has effectively amended a substantive rule. *See, e.g., Alaska Prof'l Hunters Assoc.* v. *FAA*, 177 F.3d 1030, 1034 (D.C. Cir. 1999). That proposition is consistent with this Court's opinion in *Guernsey Memorial Hospital*—a case the Secretary curiously chooses not to cite despite the D.C. Circuit's reliance on it in *Paralyzed Veterans*. As this Court explained in *Guernsey*, "APA rulemaking would still be required if [the interpretive rule] adopted a new position inconsistent with any of the Secretary's existing regulations."

514 U.S. at 100. *Guernsey* fully supports the court of appeals' decision in *Monmouth*.[24]

Indeed, whether Ruling 97-2 itself is deemed substantive or merely interpretive in form, there is no question that the Ruling effectively changed the underlying *substantive* DSH regulation codified at 42 C.F.R. § 412.106(b)(4). The regulation in effect when the Ruling issued allowed hospitals to count only those days for which a Medicaid-eligible patient was "entitled" to have Medicaid payment made on his or her behalf. Ruling 97-2 adopted a new rule permitting a hospital to count all Medicaid-eligible days, regardless of whether the patient was entitled to have Medicaid payment made for those days. App. 51a-52a.

If there were any doubt that Ruling 97-2 effectively amended the DSH regulation, it was eliminated in 1998, when the Secretary promulgated a new DSH regulation (after notice and comment) stating that, for cost reporting periods beginning on or after October 1, 1998, the numerator of the Medicaid Fraction would include days attributable to patients who were "eligible" for Medicaid but not entitled to Medicare Part A benefits. 63 Fed. Reg. 40,954, 41,004 (July 31,

---

[24] No precedent supports the Secretary's idea that the APA's notice and comment rulemaking requirements were inapplicable to Ruling 97-2 because the ruling worked to the benefit of some providers. Pet. 26. If they had been given the chance, some Medicare providers that are not DSH hospitals might have had something to say about the new rule benefiting their competitors, and if DSH hospitals had been given the chance, they might have objected to the Ruling's purported ban on reopening. But, more importantly, it is not for an agency to decide unilaterally whether those affected by a proposed rule (adversely or otherwise) deserve advance notice and an opportunity to comment on the rule. The exception the Secretary apparently desires would swallow the APA's notice-and-comment rulemaking requirements.

1998).[25] The Secretary made clear that the agency was making this substantive change "to conform the regulations to HCFA Ruling 97-2 (and hence to the four adverse circuit court decisions)," and indeed, expressly left Ruling 97-2 itself in place as the governing substantive rule for cost reporting periods beginning before October 1, 1998. *Id.* at 40,985. Thus, the D.C. Circuit properly called the Secretary's action for what it was despite some of what the Secretary said when the Ruling issued. The Secretary's desire for a replay does not warrant review on certiorari.

Monmouth's result also follows from the retroactive reach of Ruling 97-2. Despite the Secretary's claim that the agency's acquiescence was only "prospective," Ruling 97-2 plainly supplied a new rule not only for future periods, but also for prior periods that had not yet been settled when the Ruling was issued in February 1997. In terms of its retroactive effect, then, the 1997 Ruling is not different in any material respect from the retroactive rule invalidated by this Court in *Bowen* v. *Georgetown University Hospital*, 488 U.S. 204 (1988). Like the 1984 cost limit schedule at issue in *Georgetown*, the 1997 Ruling established a new substantive standard applicable to payments to hospitals for services rendered in prior periods. Just as the cost limit schedule in

---

[25] The Secretary is incorrect to the extent he suggests that the 1998 notice-and-comment rulemaking transformed Ruling 97-2 from a confession of past legal error to a purely prospective change in the law. Pet. 26 n.6. Ruling 97-2 was a *fait accompli* by the time the new regulations were offered for comment, and comment on the Ruling itself (including its purported ban on reopening) was not invited. *See Nat'l Tour Brokers Ass'n* v. *United States*, 591 F.2d 896, 902 (D.C. Cir. 1978) (invalidating ICC rulemaking where comments were sought only after rules were finalized; "We doubt that persons would bother to submit their views, or that the Secretary would seriously consider their suggestions after the regulations are a Fait accompli.") (internal quotations and citation omitted).

Georgetown applied retroactively to payments for services rendered during a period beginning July 1, 1981, Ruling 97-2 applied retroactively to payment for services rendered in cost reporting periods that ended before February 1997 but were settled after that date.

Under *Georgetown,* the Secretary simply does not have authority to promulgate a rule with retroactive effect, unless the new rule merely supplants a rule that was invalid because it conflicted with the statute itself. *See Manhattan Gen. Equip. Co.*, 297 U.S. at 135. The Secretary's determination to proceed retroactively in Ruling 97-2 thus furnishes another independent reason to sustain *Monmouth*'s reading of Ruling 97-2 as a concession by the Secretary that his old rule was unlawful.

Indeed, that concession appears on the face of the Ruling. Although the Secretary describes Ruling 97-2 as merely a "prospective acquiescence" in four adverse circuit rulings, Pet. 18, it is not possible to "acquiesce" in or determine to "follow the holdings" of those particular decisions only "prospectively." App. 49a-50a. The circuit courts uniformly held that the Secretary's interpretation of Medicaid-eligible days was contrary to statute. The Secretary cannot "prospectively acquiesce" in decisions that, by their very terms, require the conclusion that the Secretary's interpretation was *never* lawful.

For all these reasons, it was perfectly appropriate for the D.C. Circuit to credit what the Secretary actually did when the agency issued Ruling 97-2—that is, notify his intermediaries that his old rule was inconsistent with law—over some of what the agency said it was doing at the time. Courts review agency action, not the agency's own self-serving characterizations.[26] The agency's professed "belief" that its prior DSH rule was permissible (*see* App. 51a) is not incompatible with the D.C. Circuit's conclusion that the Ruling gave notice that the prior rule nevertheless was, in fact, inconsistent with the plain meaning of the DSH statute.

2. *Baystate* also was correctly decided. Following *Monmouth*, the only additional question raised by *Baystate* was whether the respondent hospitals were entitled to the mandatory reopening due them under subsection (b) if they did not request discretionary reopening under subsection (a). Notice of inconsistency with law is the only stated "precondition" that "triggers" the reopening obligation under the reopening regulation that was in effect in 1997. *See* 67 Fed. Reg. at 50,096-97. The Secretary tacitly admitted as much when he amended his reopening regulations in response to *Monmouth* without suggesting that a hospital must request reopening as a precondition to mandatory reopening under subsection (b). *See id.* The D.C. Circuit therefore was correct in holding that no additional conditions beyond a notice of inconsistency were necessary to trigger mandatory reopening.

---

[26] *See Appalachian Power Co.* v. *EPA*, 251 F.3d 1026, 1033 (D.C. Cir. 2001) ("whether an agency has in fact reopened an issue [for comment] is dependent upon the entire context of the rulemaking including all relevant proposals and reactions of the agency, and not just on the agency's stated intent") (internal quotations and citation omitted).

CONCLUSION

For the foregoing reasons, the Petition should be denied.

Respectfully submitted,

CATHERINE E. STETSON
HOGAN & HARTSON L.L.P.
555 13th Street, N.W.
Washington, DC 20004
(202) 637-5600

* CHRISTOPHER L. KEOUGH
JOHN M. FAUST
STEPHANIE A. WEBSTER
VINSON & ELKINS L.L.P.
1455 Pennsylvania Ave., N.W.
Washington, DC 20004
(202) 639-6500

*Counsel of Record

Counsel for Respondents Baystate Health Systems, et al.

February 2006

(3)

No. 05-936

In the Supreme Court of the United States

MICHAEL O. LEAVITT, SECRETARY OF HEALTH AND HUMAN SERVICES, PETITIONER

v.

BAYSTATE HEALTH SYSTEMS, DBA BAYSTATE MEDICAL CENTER, ET AL.

ON PETITION FOR A WRIT OF CERTIORARI TO THE UNITED STATES COURT OF APPEALS FOR THE DISTRICT OF COLUMBIA CIRCUIT

REPLY BRIEF FOR THE PETITIONER

PAUL D. CLEMENT
Solicitor General
Counsel of Record
Department of Justice
Washington, D.C. 20530-0001
(202) 514-2217

TABLE OF AUTHORITIES

Cases: Page

Bartlett Mem'l Med. Ctr., Inc. v. *Thompson*, 347 F.3d 828 (10th Cir. 2003) 2

Bowen v. *Georgetown Univ. Hosp.*, 488 U.S. 204 (1988) 10

Cabell Huntington Hosp., Inc. v. *Shalala*, 101 F.3d 984 (4th Cir. 1996) 6

Cheney v. *United States Dist. Ct.*, 542 U.S. 367 (2004) 3

Erringer v. *Thompson*, 371 F.3d 625 (9th Cir. 2004) 3

Heckler v. *Ringer*, 466 U.S. 602 (1984) 7

Jewish Hosp., Inc. v. *Secretary of HHS*, 19 F.3d 270 (6th Cir. 1994) 6

MCI v. *AT&T*, 512 U.S. 218 (1994) 2

Monmouth Med. Ctr. v. *Thompson*, 257 F.3d 807 (D.C. Cir. 2001) 1, 2

Paralyzed Veterans of Am. v. *D.C. Arena L.P.*, 117 F.3d 579 (D.C. Cir. 1997), cert. denied, 523 U.S. 1003 (1998) 1

Plant v. *Spendthrift Farm, Inc.*, 514 U.S. 211 (1995) 10

Scheidler v. *NOW*, 126 S. Ct. 1264 (2006) 8

Shalala v. *Guernsey Mem'l Hosp.*, 514 U.S. 87 (1995) 3

Thomas Jefferson Univ. v. *Shalala*, 512 U.S. 504 (1994) 9

United States v. *Mendoza* 464 U.S. 154 (1984) 4

United States v. *Recio*, 537 U.S. 270 (2003) 2

Case—Continued: Page

Your Home Visiting Nurse Servs., Inc. v. *Shalala*, 525 U.S. 449 (1999). 8

Statutes and regulation:

Medicare Act, Tit. XVIII, 42 U.S.C. 1395 *et seq.*:

42 U.S.C. 1395*oo*(f)(1) 2

28 U.S.C. 1391(e) 2

42 C.F.R.:

Section 405.1885(a) 4, 7, 8

Section 405.1885(b) 4, 8, 9

Miscellaneous:

Christopher L. Keogh, *CMS Reverses Application of Payment-Reduction Factor to Part B Inpatient Ancillary Services* Healthcare Fin. Mgmt. (2002) 6

REPLY BRIEF FOR THE PETITIONER

The court of appeals, based on its prior decisions in *Monmouth Medical Center* v. *Thompson*, 257 F.3d 807 (2001), and *Paralyzed Veterans of America* v. *D.C. Arena L.P.*, 117 F.3d 579 (1997), cert. denied, 523 U.S. 1003 (1998), has held that the Secretary must reopen Medicare payment determinations for as many as 2380 cost reports at issue in more than 275 pending cases because the Secretary, without notice-and-comment rulemaking, issued an acquiescence ruling to ensure nationwide uniformity in Medicare payments. The court of appeals reached that unprecedented result even though the acquiescence ruling, Ruling 97-2, explicitly *prohibited* reopening of closed cost reports.

The court of appeals' decision erroneously exposes the Medicare program to staggering (and previously unforeseeable) financial and administrative burdens and threatens to chill future agency acquiescence rulings to the detriment of agencies, private parties, and the courts. It conflicts with decisions of other courts of appeals on whether the Secretary can be ordered to reopen final Medicare determinations contrary to his express direction, and whether an agency may change an interpretive rule absent notice-and-comment rulemaking. And it cannot be reconciled with this Court's decisions compelling the conclusion that mandamus relief is not available for parties, such as respondents, that slept on their rights and now seek a form of administrative relief—reopening—that is inherently discretionary. Review by this Court is warranted.

1. Respondents contend that the circuit conflicts presented by the decision below are not worthy of this Court's review. Br. in Opp. 11-14. That contention lacks merit.

a. Respondents argue that there is no conflict on whether the court of appeals in this case correctly held that *Mon-*

mouth applies to hospitals such as respondents that (unlike the hospitals in *Monmouth*) never sought reopening. Br. in Opp. 8-9, 10-12. Respondents concede (*id.* at 9, 11-12), however, that *Monmouth* conflicts with the Tenth Circuit's decision in *Bartlett Memorial Medical Center, Inc.* v. *Thompson*, 347 F.3d 828, 838-840 (2003), on the critical threshold question in this case: whether Ruling 97-2 triggered a mandatory duty to reopen. Respondents do not dispute that *Monmouth*'s holding on that question was a fundamental premise of the decision below. Pet. App. 6a-7a. Thus, resolution of the *Monmouth-Bartlett* conflict in the government's favor would necessarily require the reversal of the decision below. The conflict therefore is squarely presented and merits this Court's review. See, *e.g.*, *United States* v. *Recio*, 537 U.S. 270, 274 (2003) (reviewing the validity of a legal rule announced in a prior decision of Ninth Circuit that had been applied in a subsequent case); cf. *MCI* v. *AT&T*, 512 U.S. 218 (1994).

Respondents contend that the conflict is "shallow" and "narrow" because it implicates only two circuits. Br. in Opp. 12. The D.C. District Court, however, has nationwide venue in mandamus actions involving the Secretary and in Medicare cases in general. 28 U.S.C. 1391(e); 42 U.S.C. 1395*oo*(f)(1). Given that nationwide venue and the unprecedented relief granted below, there is no reason to expect that providers in the future will press for reopening in any other forum.

b. As the petition explains, the courts of appeals also are divided on whether an agency may change an interpretation of a regulation without notice-and-comment rulemaking. That issue is of ongoing and obvious significance and worthy of this Court's review. Pet. 25-26. Respondents do not directly challenge those points, but argue that the issue is not presented here because the Secretary's DSH regulation was a *legislative* rule and that the circuits agree that amendments to legislative rules must be preceded by notice and comment. Br. in

Opp. 12-14, 25-27; *Shalala* v. *Guernsey Mem'l Hosp.*, 514 U.S. 87, 100 (1995). But the question decided by the court of appeals and therefore presented here is whether the Secretary was permitted to change his *interpretation* of that regulation without notice-and-comment rulemaking. On that question, the court of appeals erred, see *id.* at 99 ("[i]nterpretive rules do not require notice and comment"), and the circuits *are* divided. Compare Pet. App. 44a (after an agency interprets a regulation, it cannot alter that interpretation without notice and comment) with *Erringer* v. *Thompson*, 371 F.3d 625, 632 (9th Cir. 2004) (stating that "[a]ny rule that effectively amends a prior legislative rule is legislative and must be promulgated under notice and comment rulemaking," *but* that "no notice and comment rulemaking is required to amend a previous *interpretive* rule"). *Monmouth* expressly held that both the Secretary's original interpretation and his subsequent interpretation as reflected in Ruling 97-2 were *interpretive* rules, but that notice-and-comment rulemaking nonetheless was required before the agency could change course. Pet. App. 34a, 42a-43a (Secretary's original interpretation), 43a-44a (Secretary's subsequent interpretation). The circuit conflict is squarely presented here.

2. Respondents argue that the conflicts in the circuits do not warrant this Court's review because the Secretary did not seek immediate review of *Monmouth*. Br. in Opp. 9, 12. The government, however, should not be penalized for allowing the D.C. Circuit an opportunity to limit the consequences of its erroneous decision in *Monmouth*. Cf. *Cheney* v. *United States Dist. Ct.*, 542 U.S. 367, 379 (2004) ("the Government cannot be faulted for attempting to resolve the dispute through less drastic means."). The decision below makes clear that the D.C. Circuit will extend, not limit, *Monmouth*. Thus, review is now appropriate.

Monmouth involved only two providers that had *timely* sought reopening under the Secretary's regulations. The Secretary was not aware of any significant number of other similarly situated hospitals. And because *Monmouth* itself stressed that the two hospitals had sought reopening within the three-year deadline imposed by 42 C.F.R. 405.1885(a) (see Pet. App. 45a), the Secretary reasonably believed that the court would not extend a mandamus remedy to providers, such as respondents, that never made any administrative request for reopening at all.

The decision below makes clear that the court of appeals does not view *Monmouth* as a limited holding. Pet. 27. Moreover, when *Monmouth* was decided, the Tenth Circuit had not yet rendered its conflicting decision in *Bartlett*. Cf. *United States* v. *Mendoza* 464 U.S. 154, 160 (1984) (agencies immediately seeking review may "deprive this Court of the benefit it receives from permitting several courts of appeals to explore a difficult question"). Now that there is a square conflict with the Tenth Circuit and the D.C. Circuit has dramatically extended the reach of its *Monmouth* decision, review by this Court is plainly warranted.

Respondents also incorrectly assume that this case concerns only the meaning of Ruling 97-2 and a previous version of Section 405.1885(b). *Monmouth* concluded more broadly that an acquiescence ruling, even when it only departs from a prior interpretive rule, must be a nullity because it was not preceded by notice-and-comment rulemaking. Pet. App. 43a-44a. That holding is of significant and ongoing importance to federal agencies that regularly must consider whether to acquiesce in adverse circuit precedent (and often must do so promptly). In this case, the court of appeals held that the Secretary's routine acquiescence for one Medicare cost item resulted in a completely unforeseeable and mandatory duty retroactively to calculate cost reports for providers that

waited five to eight years to challenge those reports. The decision, if not corrected, would create significant confusion and substantial disincentives for agencies to acquiesce in circuit precedent. The net effect of respondents' position would create substantial incentives for unnecessary litigation. The government would need to seek certiorari, rather than try to limit the reach of adverse decisions, and the costs of acquiescence would needlessly increase.

Furthermore, the Secretary's amendment of the reopening rule does not ameliorate the immediate consequences directly imposed by the decision below even in the Medicare context. Pet. 11, 27-30. Respondents argue that the government's $2.8 billion estimate of the potential costs on the DSH issue alone is speculative, different from previous estimates, and not part of the record below. Br. in Opp. 19-20. But CMS's most recent $2.8 billion estimate was prepared after a careful analysis and for reasons unrelated to this litigation, *i.e.*, in connection with the agency's *public* financial statement. Pet. 27 & n.7. The Secretary has *always* estimated that the hospitals' claims, if fully successful, could result in payments totaling between $1 billion and $3.25 billion. *Ibid.*; Br. in Opp. 19. Such a massive drain on the Medicare Trust Fund, as well as the tremendous administrative burden associated with reopening potentially thousands of previously settled cost reports at issue in the 275 cases pending in the district court, merits this Court's review.[1]

---

[1] Contrary to respondents' assertion (Br. in Opp. 1, 10, 19-21), the Secretary has not suggested that the potential financial and administrative impact of the court of appeals' decision is speculative. The government has simply objected to further proceedings in the district court until this Court has completed its review of the decision below. In addition, the Secretary reasonably believes that compliance with the decision will impose a tremendous burden on the agency and divert its scarce auditing resources to reviewing stale cost report information. Pet. 28. Respondents challenge that assertion as "exaggerate[d]."

Finally, respondents do not dispute that many providers have filed similar mandamus actions that are governed by the Secretary's prior reopening regulation and that seek to extend *Monmouth* to cost issues other than DSH payments. Pet. 29-30. Indeed, respondents' counsel has urged hospitals to file similar mandamus actions, "[f]ollowing [*Monmouth*'s] line of reasoning," in the District of Columbia based on other prospective-only changes in policy. C. L. Keogh, *CMS Reverses Application Of Payment-Reduction Factor To Part B Inpatient Ancillary Services*, Healthcare Fin. Mgmt. (2002).

3. In defense of the court of appeals' decision on the merits, respondents attack the Secretary's original methodology for DSH payment determinations. Br. in Opp. 3-5, 22-23. The Secretary believes (as Ruling 97-2 itself stated) that his prior, longstanding interpretation was proper,[2] but that acquiescence nonetheless was appropriate to ensure national uniformity in light of adverse circuit precedent. Pet. App. 51a. The issue here, however, is not the validity of the Secretary's prior interpretation. The relevant question rather is whether respondents are entitled, through the extraordinary remedy of mandamus, to force the Secretary to recalculate Medicare payments even though they first challenged those payments *five* to *eight years* after the determinations became final. The answer to that question is clearly no, because respondents both failed to invoke the prescribed statutory and regulatory remedies and failed to show an indisputable right of recovery.

"overblown," and "misleading" (Br. in Opp. 21), but the Secretary respectfully submits that he is in a far superior position than respondents to judge the complexity and burdens from review and recalculation of DSH payments for cost years more than ten years old.

[2] Strong dissents in two decisions approved the Secretary's position. See *Cabell Huntington Hosp., Inc.* v. *Shalala*, 101 F.3d 984, 991 (4th Cir. 1996) (Luttig, J., dissenting); *Jewish Hosp., Inc.* v. *Secretary of HHS*, 19 F.3d 270, 276 (6th Cir. 1994) (Batchelder, J., dissenting).

a. Admitting that they did "nothing" (Br. in Opp. 18) to exhaust their claims before the Secretary, respondents argue that seeking reopening would have been futile because reopening was prohibited by Ruling 97-2. But respondents could have *appealed* their initial DSH payment determinations to the Provider Reimbursement Review Board (PRRB), and then sought *direct* judicial review in the manner provided by the Medicare Act. Pet. 12-13. If they had, they might have obtained precisely the relief that they now seek: recalculation of their original DSH determinations under the methodology later adopted in Ruling 97-2. Other hospitals in fact obtained that relief after they appealed and sought judicial review. Pet. 13 n.3; Br. in Opp. 5 & n4. Respondents thus did not invoke that "adequate remedy * * * for challenging all aspects of the Secretary's denial of their claims for payment." *Heckler* v. *Ringer*, 466 U.S. 602, 617 (1984).

In all events, even if reopening were the only relevant focal point, as respondents maintain (Br. in Opp. 16-18), they never invoked that remedy either, unlike the hospitals in *Monmouth* that timely sought reopening within three years of the determinations as required by Section 405.1885(a)—the only regulation that permits reopening at the behest of providers. Pet. 20. Any effort by respondents to obtain reopening therefore is time-barred, in addition to being foreclosed on the merits. The hospitals' excessive delay before challenging their final Medicare payment determinations is alone sufficient to preclude them from the *equitable* remedy of mandamus.[3]

---

[3] Given the government's consistent position that reopening of DSH determinations would impose wholly unwarranted and potentially far-reaching liability on the Medicare Trust Fund in favor of hospitals that slept on their rights, respondents' suggestion (Br. in Opp. 9, 19) that the government has conceded that the equities lie in their favor and that the Secretary suffers no prejudice from the court of appeals' decision is baseless.

b. Respondents' reliance on the principle that an agency must follow its own regulations is misplaced. Br. in Opp. 15-16. Since the inception of the reopening regulation in 1972, the Secretary has always considered that regulation to be entirely discretionary. Pet. 15-17. Respondents have pointed to nothing in the regulation that gives them a right to demand reopening (much less a clear and undisputable right), and to do so contrary to the Secretary's express directive in Ruling 97-2. In fact, they admit that "[t]he only reopening that a hospital has any role in initiating is *discretionary* reopening under subsection (a)." Br. in Opp. 17 (emphasis added).

Respondents nonetheless argue (Br. in Opp. 24) that Section 405.1885(b) must be read to require reopening, even when the Secretary has prohibited it, or subsection (b) "would serve no purpose not already subsumed within subsection (a)." But any arguable superfluity would not justify reading the regulation contrary to the Secretary's manifest intent. *E.g.*, *Scheidler* v. *NOW*, 126 S. Ct. 1264, 1273-1274 (2006). In any event, there is nothing superfluous about subsections (a) and (b). Section 405.1885(a) confers discretion not only on intermediaries, but also on the PRRB and the Secretary if they (rather than an intermediary) entered the decision that the provider seeks to reopen, if a motion is made within three years. By contrast, Section 405.1885(b) is directed only to intermediaries and specifies that reopening "shall" occur when the Secretary himself explicitly instructs the intermediary to reopen. Pet. 14-17. Thus, while Section 405.1885(a) "generously gives [providers] a second chance to get the decision changed" (*Your Home Visiting Nurse Servs., Inc.* v. *Shalala*, 525 U.S. 449, 455 (1999)), Section 405.1885(b) allows the Secretary, on his own initiative, to identify errors in intermediary determinations and to *direct* the intermediaries to correct them. As we demonstrate in the petition (at 15-17), Section 405.1885(b) creates a contingent duty owed by the

intermediary *to the Secretary* in accordance with their bilateral contractual arrangement; it creates no duty owed by either an intermediary or the Secretary to providers. Respondents make no effort to refute this showing that Section 405.1885(b) creates no clear duty owed *to them*, a necessary prerequisite for mandamus relief. Pet. 15-16 & n.4.

The Secretary's reading not only comports with the text and his longstanding interpretation, but also with the well-settled understanding of reopening as inherently discretionary and non-reviewable. Pet. 17. It also comports with Congress's stringent time-requirements for appealing payment determinations under a program as complex and massive in size as Medicare. The Secretary's eminently reasonable interpretation was therefore binding on the court of appeals. *Thomas Jefferson Univ.* v. *Shalala*, 512 U.S. 504, 505 (1994).

Respondents defend the court of appeals' reading of Ruling 97-2 as the Secretary's concession of an error of law (despite the Ruling's express statement to the contrary) on the ground that any other reading would have required the Secretary to promulgate a new legislative regulation in order to acquiesce in circuit precedent. Br. in Opp. 24-27. But it has never been the law that an agency must issue such a regulation to effectuate what quintessentially is a *litigation* judgment. Pet. 25-26. Moreover, any procedural defect in Ruling 97-2 would, at most, permit a court to invalidate the Ruling until notice and comment had been completed. It would not authorize a court to strike the Ruling's critical provision expressly *prohibiting* reopening while enforcing its substantive provision. Pet. 19.

Respondents also err in arguing that the Secretary's prior DSH determinations must have been void *ab initio* because Ruling 97-2 applied the new DSH payment methodology for costs incurred by hospitals in prior years if the cost reports were not yet finally settled or were still pending on review. Br. in Opp. 6-7, 27-28. In respondents' view (*ibid.*), the Ruling